



Florida Maternal Mortality Review Committee (Florida MMRC) Draft

Florida MMRC is an ongoing surveillance process that examines Pregnancy-Associated Deaths (PAD) and aims to decrease maternal mortality.

PAD is a death of a pregnant woman from any cause during pregnancy or within 1 year of pregnancy, **regardless** of the duration and site of pregnancy.

Pregnancy-Related Death (PRD) is a PAD **directly attributable** to pregnancy complications caused by acute and chronic health conditions.

43

PRDs were identified out of 64 PAD cases selected for review.

19.5

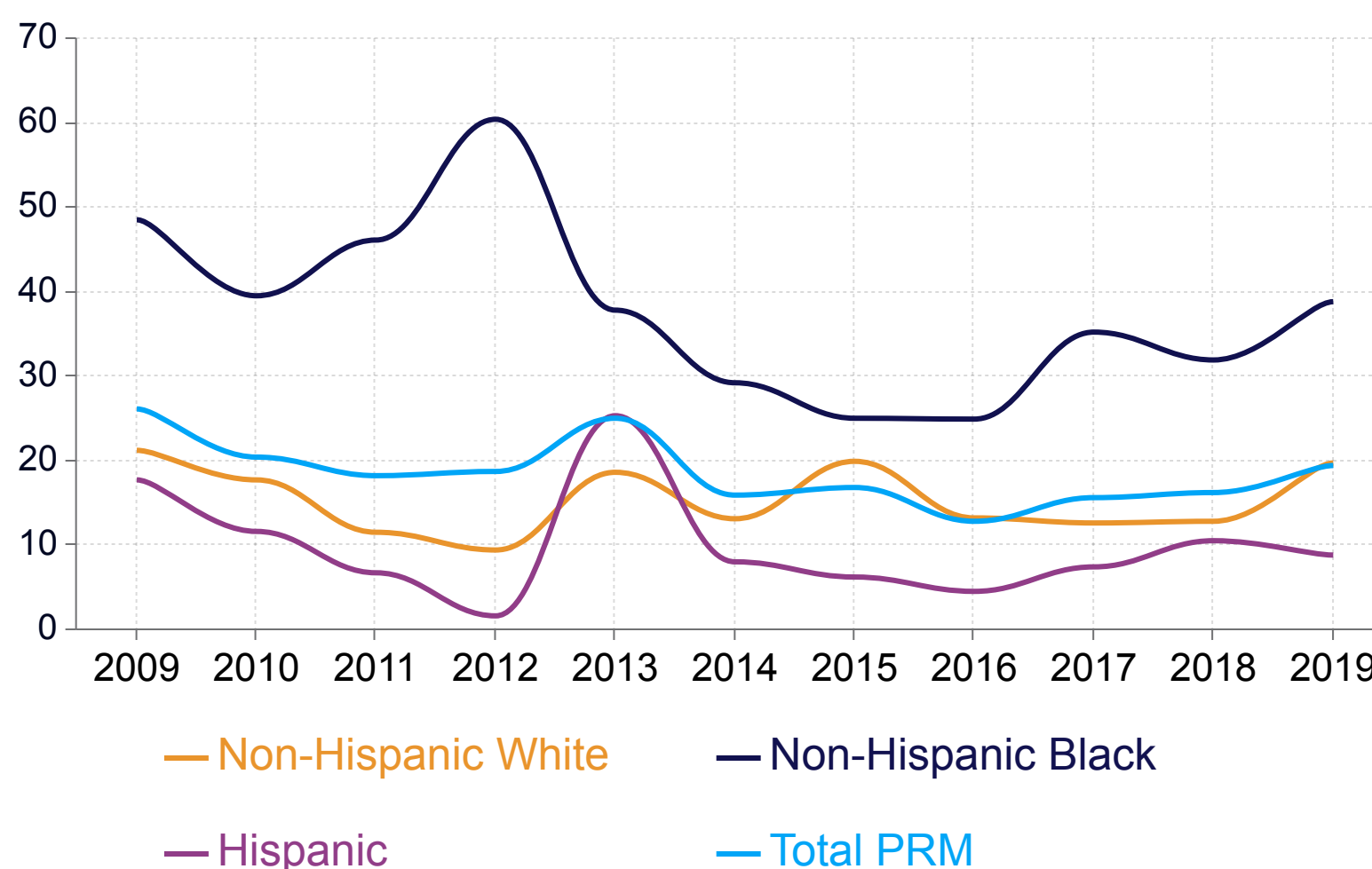
The pregnancy-related mortality ratio per 100,000 live births.

2X

A non-Hispanic Black woman was twice as likely to experience a PRD than a non-Hispanic White woman.

Pregnancy-Related Mortality Ratios by Race/Ethnicity

Florida, 2009–2019



1. Thrombotic Embolism

2. Hypertensive Disorder

FOUR LEADING CAUSES OF PRDs

3. Cardiovascular Conditions

4. Infection

Risk Factors

77%

PRDs occurred during the **post-partum** period.*

42%

PRDs occurred **before** hospital discharge.

35%

PRDs occurred **after** hospital discharge.

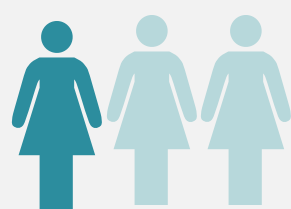
3 in 4

PRDs occurred in women with an elevated body mass index.



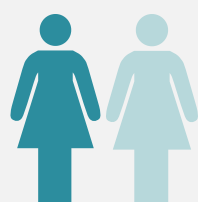
1 in 3

PRDs occurred in women 35+, who are considered to be higher risk.



1 in 2

PRDs occurred in women who had a Cesarean delivery.



84% of Cesarean deliveries were medically necessary.

Recommendations

OPTIMAL HEALTH

Become as healthy as you can before getting pregnant.

COMMUNICATION

Improve care coordination, including communication between providers and patients.

EARLY WARNING SIGNS

Incorporate maternal early warning system to monitor and assess patients' status to guide prompt treatment.

FPQC RECOMMENDATIONS

Follow the Florida Perinatal Quality Collaborative (FPQC) Obstetric Hemorrhage and Hypertensive Initiative guidelines.**

ACCESS TO MENTAL HEALTH SERVICES

Improve access to mental health care services before, during, and after pregnancy.

Florida MMRC determined that 67% of PRDs were potentially preventable at the individual, provider, and/or system level.

Notes: *This category includes deaths when the initiating adverse event may have happened antepartum, intrapartum, or postpartum. ** View FPQC initiative guidelines at <https://health.usf.edu/publichealth/chiles/fpqc/>

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For More Information Visit:

<http://www.floridahealth.gov/statistics-and-data/PAMR/index.html>

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